Massage Association of Australia Ltd

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INFORMED CONSENT

Please take a moment to carefully read the following and sign where indicated.

CONSENT FOR THERAPY

I understand that:

- The relationship between the client/patient and the therapist is a confidential one and that all information provided to the therapist is to be kept confidential. If a referral to another health care practitioner is required I agree to sign an 'AUTHORISATION TO RELEASE HEALTH CARE INFORMATION' form to comply with legislation relating to confidentiality of client/patient information.
- My body will be properly draped at all times for comfort, security and warmth.
- The therapy is solely for the purpose of massage, remedial massage or myotherapy and that the therapist and the clinic has the right to be free from any unwanted, harmful, offensive, and/or physical contact or behaviour.
- I will inform the therapist of any discomfort, so that the application of pressure or strokes may be adjusted to my level of comfort. I have the right to request and require that any procedure or technique be modified, changed, stopped, or simply not performed.
- The information I have given is accurate and I agree to update the therapist of health changes at future appointments as appropriate and understand that there shall be no liability on the therapist's part should I forget to do so. I agree to hold harmless the establishment, all management, including other clinic therapists, from and against any and all claims.
- It may be necessary to obtain permission from my medical practitioner, to receive or continue therapy. Since massage, remedial massage and myotherapy are contraindicated for some serious medical conditions, it may be necessary to obtain my doctors release or prescription before beginning therapy. I understand that the offered therapy is not a substitute for a medical examination or diagnosis and is an ancillary treatment.
- The Therapist is a Nationally Qualified Massage, Remedial Massage and/or Myotherapist
- The benefits of therapy and discomfort that I may feel have been explained.

The above information is accurate to the best of my knowledge and by signing this form, I also give consent for future sessions. I hereby give my permission to receive massage, remedial massage or myotherapy.

☐ As a minor I have been informed in the presence of my guardian.

Should I have to cancel an appointment for any reason, I agree to give the clinic 24 hours notice.

Client/Patient's Signature: ___________________________ Date: ________________

Client/Patient's Name: _____________________________

(Original to Client/Patient File – Copy to Client/Patient)

AUTHORISATION TO RELEASE HEALTH CARE INFORMATION

Client/Patient's Name: ________________________________ Date of Birth: _____________
I request and authorize:
Therapist's Name: ____ to

release my health care information to:

Name: ____

Address: ____

City: ______________________________ State: ____________ Post Code: _________

And for the therapist to discuss my health care information with my nominated person/s. This request and authorization applies to: *(please tick most suitable box)*

☐ Health care information relating to the following treatment, condition or dates:

☐ All health care information

☐ Other:

I have provided the therapist with up to date and accurate information relating to my healthcare information.

I understand that this transfer of information is required to better enable the therapist and the person/s I have nominated to formulate the best possible Treatment and Care Plan for my wellbeing.

I understand that if I decide not to sign this Authorisation I may not be able to receive treatment at the Clinic and that any existing Health Care Information held by the Clinic may be destroyed.

Client/Patient Signature: Date Signed:

THIS AUTHORISATION COMPLIES WITH LEGISLATION RELATING TO CONFIDENTIALITY OF CLIENT/PATIENT INFORMATION

THIS AUTHORISATION EXPIRES ON [nominated date] __________ OF THE YEAR IT IS SIGNED.

(Original to Client/Patient File – Copy to Client/Patient)